Veterans Health Administration
Department of Veterans Affairs
Washington, DC 20420

M-2, Part VIII

October 7, 1992

1. Transmitted is a complete revision of Veterans Health Administration Manual M-2, "Clinical Programs," Part VIII, "Rehabilitation Medicine Service." Because of the many changes, brackets have not been used to indicate the changes.

2. Principal changes are:

a. Chapter 1: Includes a statement of policy and reporting requirements.

b. Chapter 3: Is replaced by a new Chapter 3, "RMS (Rehabilitation Medicine Service) Sections."

c. Chapter 5: Is replaced by a new Chapter 5, "Driving Training for the Handicapped Veteran."

d. Chapter 6: Is replaced by a new Chapter 6, "Work Restoration Program."

e. Chapter 7: Is replaced by a new Chapter 7, "Education in RMS (Rehabilitation Medicine Service)."

f. Chapter 8: Is replaced by a new Chapter 8, "Research in RMS (Rehabilitation Medicine Service)."

g. Chapter 9: Is replaced by a new Chapter 9, "Scope of Practice."

h. Chapter 10: Is deleted.

3. Filing Instructions

Remove pages	Insert pages
Cover through vi	Cover through iv
1-1 through 1-8	1-i through 1-10
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4. RESCISSIONS: M-2, Part VIII, dated July 15, 1966; Circulars 10-87-13 (Supp. 1), 10-87-15 (Supp. 1); 10-87-81 (Supp. 1); 10-87-133, 10-88-113, 10-90-025, and Interim Issue 10-66-44, 10-70-16, 10-74-28, 10-74-30, 10-75-03, 10-76-16, 10-76-17, 10-76-31, 10-77-25.

James W. Holsinger, Jr., M.D.
Chief Medical Director

Distribution: RPC: 1031

FD

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DEPARTMENT OF
VETERANS AFFAIRS

CLINICAL PROGRAMS
Rehabilitation Medicine Service

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M-2, "Clinical Programs," Part VIII, "Rehabilitation Medicine Service," is published for the compliance of all concerned.

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CHAPTER

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RESCISSIONS

The following material is rescinded.

1. Complete Rescissions

a. Manual

M-2, Part VIII, dated July 15, 1955, and changes 1 through 4
M-2, Part VIII, dated July 15, 1966,
M-2, Part VIII, change 1, dated June 19, 1970
M-2, Part VIII, change 2, dated September 22, 1971
M-2, Part VIII, change 3, dated July 2, 1981

b. Interim Issues

II 10-66-44
II 10-70-16
II 10-74-28
II 10-74-30
II 10-75-3
II 10-76-16
II 10-76-17
II 10-76-19
II 10-76-31
II 10-77-25

c. Circulars

10-87-13 and Supplement 1
10-87-15 and Supplement 1
10-87-81 and Supplement 1
10-87-133
10-88-113
10-90-025

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CHAPTER 1. ADMINISTRATION OF RMS (REHABILITATION MEDICINE SERVICE)

CHAPTER 1. ADMINISTRATION OF RMS (REHABILITATION MEDICINE SERVICE)

1.01 STATEMENT OF POLICY

a. RMS is an organizational unit characterized by the utilization of physical, mental, psychosocial, educational and vocational services for the prevention and reduction of disability. In order to prepare patients for optimum independence in their environments, diagnosis, treatment and prevention are utilized.

(1) Sections comprising the service employ the following treatment modalities:

(a) Medical,

(b) Physical,

(c) Cognitive,

(d) Psychosocial,

(e) Educational, and

(f) Vocational.

(2) The Rehabilitation Program consists of three components:

(a) Patient care,

(b) Education, and

(c) Research.

b. As one of the major clinical services in VA (Department of Veterans Affairs), RMS has a three-fold mission:

(1) RMS emphasizes comprehensive rehabilitation of the veteran. Using an interdisciplinary approach, RMS aims to prevent or limit impairment, disabilities and handicaps of individual patients while improving their functional abilities, independence, and quality of life. The standard of care shall be directly comparable to the current state-of-the-art available in the academic and private sectors of health care. The quality and appropriateness of services offered is ensured throughout RMS by an ongoing process of monitoring and feedback.

(2) In order to support patient care at a high level of competence, RMS is committed to the education of rehabilitation professionals necessary to carry out those functions. In addition, RMS participates in the education of other health care professionals and of society as a whole.

(3) RMS supports, encourages, and carries out clinical and basic science research directed toward the advancement of the art and science of medical rehabilitation.

1.02 GENERAL PROVISIONS

a. RMS has a defined philosophy with stated goals and objectives for rehabilitation

which are in accordance with the VA facility's mission. Goals and objectives for each patient will be reviewed, evaluated and revised according to:

(1) Patient needs,

(2) Established target dates, and

(3) Requirements of appropriate accreditation bodies.

b. RMS encourages investigation and implementation of new developments and practices in rehabilitation to enhance the quality of patient care. This will be accomplished through:

(1) Research,

(2) Education,

(3) Practical application of theory, and

(4) Contributions to professional literature.

c. Administrative Organization

(1) A medical center approved organizational chart and functional statement will delineate responsibility, authority, relationships of therapy sections, service delivery and accountability.

(2) A master staffing plan for RMS must be developed by the Chief or Acting Chief, RMS, which recommends the number, category and grade levels of personnel required to deliver care.

(3) These plans will be:

(a) Reviewed annually,

(b) Revised when appropriate in consultation with the appropriate governing body, and

(c) Proposed to and approved by the medical center Director.

(4) RMS, VA Central Office, will be contacted by the Chief, RMS, or designee for approval, prior to the implementation of any proposed organizational and major program changes made in RMS therapy sections.

d. RMS shall carry out quality assurance and peer review activities.

e. RMS will meet the standards for rehabilitation medicine services published in the manuals of accreditation under which the medical center is evaluated.

f. RMS will use qualified consultants for program planning, implementation and evaluation.

g. The Chief, RMS, will be a board certified physiatrist, unless otherwise authorized by VA Central Office. It is emphasized that the Chief, RMS, has the authority and responsibility for the clinical management of RMS programs.

(1) The Chief, RMS, is responsible for:

(a) The establishment of service goals,

(b) The planning and implementation of programs within the policies and procedures of VHA (Veterans Health Administration), and

(c) The quality of care provided by RMS staff physicians, residents and therapy staff.

(2) Program implementation is made in collaboration with appropriate services within the facility and, where applicable, with those in the community.

(3) Medical supervision for all therapy sections is provided by a physician.

(4) When a physiatrist has not been recruited, a physician designated by the medical center Director will serve as Acting Chief, RMS, until a qualified Chief, RMS, has been appointed with VA Central Office concurrence.

h. The Assistant Chief of RMS will be a board certified or eligible physiatrist, unless otherwise authorized by VA Central Office. This individual has the responsibility to carry out the mission and objectives of the department and duties delegated by the Chief, RMS; and in the absence of the Chief, RMS, becomes Acting Chief, RMS.

i. RMS staff physiatrists shall assist the Chief, RMS, in carrying out the mission of RMS Service.

(1) The staff physiatrists will be responsible primarily for:

(a) Inpatient care on RMS bed services,

(b) Prescribing treatment for in- and outpatients referred by consultations; and

(c) Providing special tests such as EMG (electromyography) and other electrodiagnostic procedures.

(2) The physiatrists work closely with the patients, their families and all rehabilitation team members which include:

(a) Rehabilitation nurses,

(b) RMS therapists,

(c) Psychologists,

(d) Social workers,

(e) Speech pathologists, and

(f) Physicians from other services.

(3) If a residency program is in effect, the physiatrists are responsible for the teaching of the residents and the patient care provided by the residents.

(4) The physiatrists participate in administration, committees, and the general teaching functions as delegated by the Chief, RMS.

j. RMS Administrator/Coordinator

(1) The RMS Administrator/Coordinator is responsible for:

(a) Directing, organizing and evaluating the administrative operation of RMS, under the supervision of the Chief, RMS; and

(b) Upon request, representing RMS in interdisciplinary planning groups at many levels to facilitate the planning, delivery and re-evaluation of integrated comprehensive care.

(2) This position may be established in medical centers only where the following criteria are met:

(a) There is a designated RMS Bed Service;

(b) The medical center has an active comprehensive Rehabilitation Program, as evidenced by at least two of the following characteristics:

1. There are a minimum of three therapy sections in RMS with at least 13 total FTEE (full-time employee equivalent) assigned to the service.

2. There is a medical school affiliation, with medical students and/or residents assigned at least 6 months out of the year.

3. New consultations to RMS (for all therapy services) number at least 60 per month, or

4. The medical center has one or more authorized, specialized programs which require intensive, interdisciplinary rehabilitation services. These may include:

a. Blind Rehabilitation,

b. CRC (Comprehensive Rehabilitation Center),

c. GRECC (Geriatric Research, Education and Clinical Centers),

d. SCI (Spinal Cord Injury), or

e. STAMP (Special Teams for Amputation, Mobility and Prosthetics/Orthotics); and

(c) The Chief, RMS, is active in clinical and academic medicine, as evidenced by any one of the following:

1. Providing primary attending physician care at least 6 months of the year for an inpatient service of not fewer than six beds.

2. Being the primary outpatient medicine care provider for patients with specific diagnoses, covering not less than 12 outpatient visits per week, and/or

3. Being Principal Investigator on a funded merit review research grant.

4. Serving on medical school faculty, and/or supervising resident physicians.

(3) Requests for exceptions to this policy should be addressed through the appropriate Regional Director to the Director, RMS (117B), VA Central Office, 810 Vermont Avenue, N.W., Washington, DC 20420.

NOTE: In line with good position management and considering current medical center requirements and priorities, RMS should determine, with local management, the need to establish or continue a RMS Administrator/Coordinator position.

k. Therapy section supervisors assist in setting the guidelines of RMS policies and procedures. They are responsible for the total management, organization, administration, supervision, and professional functions, of their respective sections.

l. The clinical training supervisor maintains contact with affiliating educational institutions and is responsible for the development, operation, revision and supervision of the clinical training programs in the clinical training supervisor's specific section.

m. The therapy staff will be competent, ethical providers of rehabilitative services.

(1) Rehabilitation therapy assistants or aides assist in the daily treatment of assigned patients under the supervision of rehabilitation therapists/specialists.

(2) Rehabilitation therapists, specialists, and assistants are responsible, within the limits of their academic preparation and approved scope of practice or clinical privileges, for the independent performance of their profession.

(a) A scopes of practice will be based on:

1. Professional standards of practice,

2. Documented academic education and training, and

3. Specific experience in the delivery of patient care.

(b) A scopes of practice is requested by the staff member, and approved under the provisions of the individual medical center policies.

n. Clerical support for RMS is provided by secretaries and clerks. The level of responsibility delegated to these positions is individually determined by the Chief, RMS, or RMS Coordinator, within established agency personnel practices.

1.03 RMS CONSULTATIONS, REFERRALS, PROGRESS REPORTS AND CLINICAL RECORDS

a. RMS personnel are responsible for complete, accurate and timely documentation of the veteran's rehabilitation care in the permanent medical record.

b. Veterans will be referred to RMS by means of Standard Form 513, Clinical Record - Consultation Sheet, or a form approved by the facility's Medical Records Committee. The medical center's RMS policy memorandum will specify method, mode and content of all referrals.

c. The consultation form will be completed with as much specificity as possible.

(1) RMS treatment programs will be prescribed or approved by a RMS physician and will be administered by the RMS staff according to clinical treatment plans.

(2) Evaluations may be completed by appropriate RMS staff based on referrals or requests from hospital team members with provisions that physician approval will be obtained within limits prescribed by local RMS policy and procedures, and governed by accrediting bodies.

d. The Chief, RMS, or physician designee, will record examination findings and recommendations on the approved form and return it within time limits specified by VA medical center policy and accrediting body guides.

e. Evaluation and treatment will be initiated according to the time frame established in the medical center's RMS Policy and Procedures Manual. The respective specialties should be involved in the complete evaluation process.

(1) The initial assessment will include the establishment of measurable goals and the development of a treatment plan which includes discharge planning and patient education.

(2) There will be an interdisciplinary treatment plan developed jointly with the referring individual, the rehabilitation staff, and the patient and/or family.

(3) Regular and frequent assessments will be performed on an interdisciplinary basis including a revision of program goals as required by the patient's condition.

(4) Discharge planning will be an ongoing collaborative function of the interdisciplinary treatment team providing information for the post hospital plan.

f. Progress notes will be written in the veteran's clinical permanent medical record to reflect the patient's condition and progress towards the rehabilitation goals. Documentation frequency shall meet the standard set in the medical center's RMS policies and procedures which must be in accordance with the accrediting agency requirements for the medical center.

g. A final note shall be prepared by each contributing section and placed in the veteran's permanent medical record. The final note shall include, but not be limited to:

(1) A diagnosis and a treatment plan;

(2) Summation of treatment and response to treatment;

(3) Frequency of treatments given and duration of treatment;

(4) Status of the veteran upon termination;

(5) Follow up treatment, program goals/objectives;

(6) A statement regarding patient health education provided and, when applicable, home program instructions; and

(7) A statement regarding satisfactory understanding of the proper operation of all adaptive equipment provided to the patient.

h. One-visit Patients. The completed referral form will document evaluation of treatment services rendered to patients on a one-visit basis. The evaluation document will become a part of the patient's permanent medical record.

i. Forms by RMS may be over-printed as approved by local VA medical center's Medical Records Committee and/or the Forms Control Officer.

1.04 HEALTH, SAFETY AND SANITATION

Current health, safety and sanitation directives as they pertain to space, personnel, fabricated articles, equipment, supplies and utilities will be observed in RMS and included in the RMS Policies and Procedures Manual. Special attention will be given to the following areas:

a. Infection Control. Infection control programs will be instituted in compliance with the VA medical center's Infection Control Committee, and current CDC (Center for Disease Control) policies.

b. CMR (Consolidated Memorandum Receipt). All CMR-listed equipment used in RMS will be on a preventive maintenance program, calibrated as necessary and, when applicable, in compliance with the OSHA (Occupational Safety and Health Administration) standards. Documentation of the calibrations will be maintained in a prominent location in the appropriate RMS clinic and in the files of the facility Engineering Service.

c. Hazardous Items. Hazardous equipment and supplies will be used only in accordance with written safety and storage regulations that conform with both the agency directives, policies and guidelines as established by local policy. MSDS (Material Safety Data Sheets) will be available according to local policy.

d. Security. Security controls will be required for all clinical areas as dictated by medical center policy.

e. Fire and Safety. The medical center's fire and safety standards and disaster plans will be followed and a copy will be maintained in each RMS section and in the RMS office. RMS plans will be formulated consistent with medical center policy and reviewed annually by all service personnel. Annual staff development sessions will be held for infection control, safety, fire and the disaster plan.

f. Swimming Facilities. RMS safety rules and Federal Health Regulations are to be adhered to for the use of swimming facilities, on or off medical center grounds:

(1) Swimming instructors and life guards will be currently qualified in life saving techniques by a nationally recognized agency, such as the American Red Cross or YMCA (Young Men's Christian Association). Each RMS instructor or life guard will be certified in either the Emergency Water Safety or Lifeguard

Training courses (or equivalent) depending upon the patient population being served.

(2) There will always be at least one such qualified person, properly attired, in the immediate pool area when the pool is in use by patients.

(3) With respect to the number of such qualified persons on duty at any one time, the ratio of such qualified persons to patients will be dictated by local needs.

g. CPR (cardiopulmonary resuscitation). Certification in CPR as per the American Heart Association is recommended for all RMS personnel who are involved in direct patient care. Yearly review of basic life support procedures should be made available to all RMS personnel.

1.05 VOLUNTEERS IN RMS

a. The services of volunteers may be utilized where appropriate to support staff efforts in RMS programs.

b. Volunteers will receive an appropriate description of their assignment and orientation by Voluntary Service prior to working on a RMS assignment.

c. Volunteers will be provided appropriate orientation and/or training in the RMS section to which they are assigned.

1.06 SUPPLIES AND EQUIPMENT

a. Supplies and equipment required for rehabilitation will be furnished and/or prescribed for eligible veterans.

b. Medical center equipment and supplies will be used primarily for the benefit of veterans participating in a RMS program. With recommendation of the RMS Chief and authorization of the medical center Director, equipment and supplies may be used by VA and non-VA individuals or organizations, provided this does not interfere with patient care, and meets safety, security and liability criteria.

1.07 AREAS AND FACILITIES

RMS areas and facilities are to be used primarily for the benefit of veterans participating in RMS programs. The Chief, RMS, or designee, is authorized to allow areas and facilities to be used by others for activities and meetings which do not interfere with patient programs. The authorization for utilization of RMS space must be in accordance with existing local medical center policy.

1.08 UNIFORMS

Uniforms for RMS personnel are required and will be issued except where local permission for deviation has been obtained.

1.09 RMS MANAGEMENT TEAM

a. The RMS Management Team consisting of the Chief, RMS Coordinator, and Section Supervisors, will meet regularly to plan, organize, staff, direct and

monitor the professional and managerial activities of the service. The final responsibility is retained by the Chief, RMS.

b. Functions of the RMS Management Team are:

(1) To assure that RMS fulfills its mission to provide comprehensive rehabilitation care to all eligible veterans requiring such services within the limits of resources provided. Achievement of this care will be monitored through appropriate Quality Assurance monitors;

(2) To establish effective and efficient use of resources with continuous mechanisms for accountability;

(3) To participate in the medical center's annual budget plan by forecasting needs for:

(a) Existing and new programs,

(b) Personnel,

(c) Space,

(d) Supplies,

(e) Equipment,

(f) Educational resources, and

(g) Consultants;

(4) To assign patient treatment to appropriate sections or individuals properly skilled and credentialed for fulfilling patient rehabilitation goals;

(5) To facilitate interdisciplinary communication;

(6) To participate in the planning of new construction, additional space, remodeling of existing facilities, and in purchasing of major equipment; and

(7) To integrate and supplement educational objectives for staff development in the areas of professional, educational and management skills.

1.10 COMPONENTS OF RMS

Based on the needs of the veteran population served by VA facilities, the following Sections may be established within RMS:

a. Educational Therapy,

b. Kinesiotherapy,

c. Manual Arts Therapy (or Vocational Rehabilitation Therapy),

d. Occupational Therapy, and

e. Physical Therapy.

NOTE: In those facilities where a Recreation Therapist, Audiologist and/or a Speech Pathologist have not been established under a separate Service, they may be organizationally placed as a Section within RMS.

1.11 ANNUAL REPORT

Copies of service annual management briefing summaries for each fiscal year will be submitted to VA Central Office no later than 1 month after the summary submission to facility management. Other statistical reports will be submitted as directed by VA Central Office.

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CHAPTER 2. RMS (REHABILITATION MEDICINE SERVICE) BED AND CONSULTATION SERVICES

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2.01 STATEMENT OF POLICY

The efficient delivery of quality rehabilitation care includes acute, intermediate and long-term care, and will be an integral part of the mission of the total facility.

2.02 GENERAL PROVISIONS

a. Consultation is provided by RMS to all other patient care activities, as requested.

b. A RMS bed service may be established in facilities upon recommendation of the Chief, RMS, with the approval of the Chief of Staff and the medical center Director. Approval by the CMD (Chief Medical Director) will be required to change the distribution of major bed programs or sub-programs for a period in excess of 90 days. Medical centers having a PM&RS (Physical Medicine and Rehabilitation Service) Residency Program will have a bed service as required by the American Board of Physical Medicine and Rehabilitation.

c. In order to provide adequate professional coverage of both the RMS bed service and other rehabilitation medicine services throughout the medical center, a minimum of two physicians, at least one of whom is a board certified/board eligible physiatrist, must be assigned to RMS. Deviation from this policy will be accomplished only with the approval of the Director, RMS, VA Central Office.

d. Beds under the responsibility of the Chief, RMS, will be reported as RMS Beds on the medical center Bed Census Report.

e. Requests for changes of bed designation should be submitted to the CMD's office through the appropriate Regional Director's office.

2.03 PURPOSE OF A RMS BED SERVICE

a. The RMS bed service provides treatment facilities and rehabilitation services to veterans who would benefit from an intensive inpatient rehabilitation program.

b. The conditions to be met in establishing new acute RMS bed services include:

(1) The proposed physician service chief must be employed at least five-eights time, and be board certified.

(2) Provision has been made to assure physician coverage 24 hours a day, 7 days a week.

(3) At least three core clinical therapy sections are available and adequate staff to assure a minimum of 3 hours of therapy per day per patient. Core clinical therapy sections include, but are not limited to:

(a) Kinesiotherapy,

(b) Occupational therapy,

(c) Physical therapy, and

(d) Audiology and speech pathology.

(4) Multidisciplinary staff is identified and, if possible, dedicated to service of rehabilitation beds, as:

(a) Rehabilitation nursing,

(b) Social work,

(c) Psychology,

(d) Recreation therapy,

(e) RMS therapies,

(f) Vocational resources, and

(g) Chaplain services.

(5) Electromyography evaluation resources are present or available.

(6) Full prosthetic/orthotic and HISA (Home Improvement and Structural Alterations) services are available in-house or through contractural agreements.

(7) A mechanism for post-discharge follow-up is available.

2.04 ADMISSION AND DISCHARGE OF VETERANS TO/FROM RMS BED SERVICE

a. Admission criteria will be established by Chief, RMS, and approved by the Chief of Staff or CEB (Clinical Executive Board).

b. Direct admission or transfer to RMS bed service will be made only after consultation with, and approval by, the Chief, RMS, or physician designee. In specific conditions, the Chief, RMS, may request admission panel discussions to assist in the arrangement for admission or for other options of treatment for patients with borderline potential for rehabilitation care.

c. When the veteran has received maximum benefits from rehabilitation treatment, but further hospitalization is required, the veteran will be transferred to the appropriate Service. The Chief, RMS, or physician designee, will initiate all transfers. Variances of opinion will be referred to the Chief of Staff.

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CHAPTER 3. RMS (REHABILITATION MEDICINE SERVICE) SECTIONS

CHAPTER 3. RMS (REHABILITATION MEDICINE SERVICE) SECTIONS

3.01 STATEMENT OF POLICY

a. The professionals from each therapy section, who deliver unique and integrated health care, are directed and supervised by the Chief, RMS, or physician designee. Exceptions to this require RMS, VA (Department of Veterans Affairs) Central Office approval. Services are rendered in accordance with policies and procedures established by RMS.

b. The interdisciplinary team, consisting of representatives from appropriate therapy disciplines and a RMS physician, consults with other services to provide comprehensive rehabilitation care.

3.02 GENERAL PROVISIONS

a. The RMS Chief or physician designee may assign treatment responsibilities to a section or sections which have personnel qualified to administer therapy modalities commensurate with:

(1) Documented professional academic education,

(2) Professional certification and/or licensure,

(3) Approved scope of practice or clinical privileges (hereafter referred to as "privileges"), and

(4) Other training experiences approved by the supervising physician.

b. Professional duties in each therapy section must be supervised by a professional from that respective discipline.

c. The primary functions of each therapy section will be to:

(1) Provide and deliver quality service to the veteran, based on the individualized "privileges" designated to each discipline.

(2) Participate as members of interdisciplinary teams.

(3) Document treatment in accordance with requirements of accreditation bodies and VA regulations.

(4) Participate in quality assurance programs and utilization reviews to ensure optimal performance in keeping with the advancing state of the art.

(5) Encourage and promote staff development and professional involvement;

(6) Establish and maintain contact with other in-house services, the general health care community, and the public.

(7) Provide clinical orientation about one's discipline to RMS and other medical center professional staff.

(8) Provide clinical education programs that meet the standards of the professional organizations.

d. The rehabilitation medicine therapy sections, of educational therapy, manual arts therapy, physical therapy and occupational therapy, may develop and implement clinical training affiliations for students pursuing a career in the designated specialty from an affiliated institution under the provisions and approvals established by VA.

e. Kinesiotherapy non-affiliated training programs for qualified candidates may be established with the approval of RMS, VA Central Office (117B).

3.03 EDUCATIONAL THERAPY

a. Educational therapy is medically prescribed to meet the educational needs of patients who present learning disabilities, vocational deficits, and psychosocial and physical dysfunctions.

(1) Qualified educational therapists administer and interpret standardized tests and assessments to provide basis for treatment planning and educational counseling.

(2) Among the resources employed by educational therapists are:

(a) Adult basic education,

(b) Remedial instruction,

(c) Job seeking skills,

(d) Creative writing expression, and

(e) High school equivalency (or GED [General Educational Development] testing).

b. The purpose of Educational Therapy is to:

(1) Administer and interpret standardized tests and assessments to provide basis for treatment planning and educational counseling.

(2) Provide academic and developmental education to increase basic educational skills.

(3) Provide ABE (adult basic education) to semi-literate veterans.

(4) Provide remedial instruction commensurate with scope of practice of the professional to those patients with educational handicaps, learning disabilities, and/or cognitive dysfunction.

(5) Structure programs for the development of creative expression in such areas as poetry, prose, drama, personal research (genealogical) and extended reading which enhance quality of life. NOTE: Entries in Veterans' Voices publication may be supported through educational therapy.

(6) Provide educational counseling in marketable job skills.

(7) Offer GED testing in authorized medical centers. NOTE: The American Council on Education administered program provides high school equivalency testing by qualified chief examiners through contracted services.

(8) Publish patient newspapers, in conjunction with journalism classes, governed by prevailing privacy and freedom of information acts.

(9) Provide training in basic computer literacy, programming and computer operations.

3.04 KINESIOTHERAPY (formerly CORRECTIVE THERAPY)

a. Kinesiotherapy is the treatment of the effects of disease, injury and congenital disorder through the use of therapeutic exercise and patient education.

(1) Through a didactic and clinical preparation in anatomy, physiology and kinesiology, the kinesiotherapist is capable of evaluating the physical status of the patient.

(2) Observation and a variety of physical fitness testing procedures serve as a basis for the kinesiotherapist to formulate and implement a program of physical exercise and activity designed to remediate the disease process.

(3) The kinesiotherapist directs medically prescribed activity which promotes general and specific conditioning and reconditioning of patients.

b. The purpose of Kinesiotherapy is to:

(1) Evaluate the patient's overall physical condition using observation and fitness testing procedures. Parameters include:

(a) Balance,

(b) Coordination,

(c) Endurance,

(d) Flexibility,

(e) Proprioception,

(f) Neuromuscular development, and

(g) Psychosocial integration.

(2) Develop and implement specific activities to promote physical conditioning and overall fitness in those patients where it is diminished because of disease or disuse.

(3) Educate and counsel patients, families and/or significant others about the effect of exercise on disability.

3.05 MANUAL ARTS THERAPY

a. Manual arts therapy is a medically prescribed, vocationally oriented program.

(1) Manual arts therapists and vocational rehabilitation specialists utilize actual or simulated work situations to assess functional levels of work potential, as well as maintain, improve or develop work skills and vocational potential.

(2) Manual Arts Therapy can also be targeted to prevent physiological or psychological deconditioning, in addition to enhancing a productive life style.

b. The purpose of Manual Arts Therapy is to:

(1) Assess and evaluate veteran's functional level with regard to work potential using job sample evaluations, work simulations, and other standardized vocational testing.

(2) Assist in appropriately modifying environments and/or structuring graded work conditioning to overcome physical limitations of veterans with disabilities which interfere with their work site and life space function.

(3) Provide structured work situations to assist with targeted behavior and attitude adjustments.

(4) Provide group work situations in which the patient's sociability and interdependence can be assessed and modified.

(5) Participate in Compensated Work Therapy (contract supported work-for-pay activities), when remuneration is appropriate as a therapeutic assessment and treatment modality.

(6) Utilize Incentive Therapy (structured work-for-pay jobs within the medical center which contribute to its mission), as appropriate to assess and shape the patient's work tolerance, work habits and performance in a normative work situation.

(7) Provide work based avocational activities that reduce the need for rehospitalization and enhance independence.

(8) Provide avocational training commensurate with a work ethic for those who, because of deficits or disability, will not reenter the job market.

3.06 OCCUPATIONAL THERAPY

a. Occupational therapy is a medically based health service administered by a registered occupational therapist who utilizes the application of goal-oriented, purposeful activity in the assessment and treatment of individuals whose function is impaired by:

(1) Physical illness or injury,

(2) Psychiatric and/or emotional disorder,

(3) Congenital or developmental learning disabilities, or

(4) The aging process.

b. The practice encompasses evaluation, treatment, instruction and consultation.

c. Specific occupational therapy services include:

(1) Evaluation and training in daily living skills;

(2) Developing perceptual motor skills and sensory-integrative and cognitive function;

(3) Developing prevocational capacities; and

(4) Designing, fabricating or applying selected orthotic and prosthetic devices.

d. Occupational therapy functional assessments and treatment methods are concerned with specific performance components and the interrelationship of these components which are consistent with their scopes of practice.

e. The purpose of Occupational Therapy is to:

(1) Administer and interpret standard, non-standard and clinical evaluations, develop and implement the written, goal-directed treatment plan.

(2) Promote independent living concept by evaluating patient's ability and training in the performance of activities of daily living tasks.

(3) Evaluate and fabricate appropriate therapeutic devices which include:

(a) Designing and fabricating splints, or

(b) Applying selected orthotic and prosthetic devices and training patients in their use.

(4) Provide consultative services in the selection and use of adaptive equipment, activities and therapeutic exercises to improve functional performance.

(5) Provide prevocational evaluations and vocational interventions which includes work hardening (i.e., work assessment, work capacity programming and employment preparation).

(6) Educate and/or counsel patients and families regarding the disability to:

(a) Promote health and the concept of "wellness," and

(b) Improve the management of the disability and the resumption of life roles in the home and community environment.

(7) Provide for and participate in treatment programs in the home after discharge by evaluating and adapting the home environment and work place for safety and ease of functioning.

(8) Provide therapeutic interventions that focus on:

(a) Joint protection/body mechanics,

(b) Positioning,

(c) Strength,

(d) Cardiopulmonary function,

(e) Coordination, and

(f) Functional abilities in daily living skills.

(9) Participate in formalized investigative studies and research for the purpose of improving the quality of patient care by means of recognized scientific methodologies and procedures.

3.07 PHYSICAL THERAPY

a. Physical therapy is a medically-based health service administered by a licensed physical therapist.

b. The licensed physical therapist utilizes the application of scientific principles for the identification, prevention, remediation and rehabilitation of acute and prolonged physical dysfunction, thereby promoting optimal health and function.

c. Physical therapy includes evaluation, treatment, instruction, and consultative services related to neuromuscular, musculoskeletal, cardiovascular, respiratory function, and other medical functions.

d. The purpose of Physical Therapy is to:

(1) Evaluate and assess the patient prior to the development of treatment plans and goals.

(2) Develop treatment goals and plans in accordance with the initial evaluation findings with treatment aimed at prevention, reducing disability or pain, and restoring lost function.

(3) Provide therapeutic interventions which focus on:

(a) Posture,

(b) Locomotion,

(c) Strength,

(d) Endurance,

(e) Balance,

(f) Coordination, and

(g) Joint mobility and flexibility.

(4) Monitor the extent to which services have met the therapeutic goals relative to the initial and all subsequent examinations.

(5) Determine the degree to which improvement occurs and, when appropriate, revise the overall treatment plan.

(6) Educate and/or counsel patients, families, and/or significant others regarding:

(a) The disability incurred and about intervention reducing the existing disability, and

(b) Improved management of any residual disability in the resumption of life roles in the home and community environment.

3.08 OTHER ALLIED HEALTH DISCIPLINES

The functional responsibilities of disciplines located within the RMS organization, but not mentioned in the preceding, may be directed by other VHA (Veterans Health Administration) manuals. These disciplines include, but are not limited to:

a. Recreation therapist,

b. Vocational rehabilitation specialist,

c. Vocational case manager,

d. Audiologist and speech pathologist,

e. Rehabilitation nurse, and

f. Prosthetist.

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CHAPTER 4. MEDICAL REHABILITATION PLANNING BOARD

CHAPTER 4. MEDICAL REHABILITATION PLANNING BOARD

4.01 GENERAL

a. The purpose of the Medical Rehabilitation Planning Board is to provide a multidisciplinary approach to complex problems in rehabilitation.

b. Cases brought before the Board may deal with problems in physical rehabilitation, psychosocial rehabilitation, vocational rehabilitation or disposition.

c. A Medical Rehabilitation Planning Board may be established at the discretion of any VA (Department of Veterans Affairs) medical center for the purpose stated.

4.02 MEMBERSHIP OF THE MEDICAL REHABILITATION PLANNING BOARD

a. The permanent membership of the Board may include:

(1) Chief, RMS (Rehabilitation Medicine Service), or designee, as chairperson,

(2) VHA (Veterans Health Administration) Vocational Rehabilitation Case Manager, and

(3) Representatives from:

(a) Audiology and Speech Pathology Service,

(b) Social Work Service, and

(c) Psychology Service.

b. The patient's staff physician, ward nurse and RMS therapist(s) will serve on the Board when a patient under their care is being reviewed.

c. The RMS secretary will serve as the official recorder for the Medical Rehabilitation Planning Board meetings.

4.03 REFERRAL OF PATIENTS TO THE BOARD

a. Referral and selection of patients for consideration by the Board will be made by:

(1) VHA vocational rehabilitation case manager or patient's physician;

(2) Other service chiefs working directly with patients; and

(3) RMS section representatives.

b. The case report will contain the following information:

(1) Name of medical center,

(2) Name of patient,

(3) Date of birth,

(4) Home address,

(5) Social Security Number,

(6) A brief statement of diagnosis(es), resulting disability, and reasons for referral to the Board, and

(7) A concise summary of:

(a) The planning and other action taken by the Board,

(b) The main elements of therapy which have been employed in treatment,

(c) The specific results obtained,

(d) The extent of the patient's participation in the rehabilitation plan, and

(e) The post hospital follow-up recommendations.

NOTE: The summary should reflect capacities for self-care, vocational activity, and leisure-time activity, with particular reference to the patient's emotional, mental and physical capacities in terms of the rehabilitation plan which was developed in conjunction with the patient.

4.04 BOARD MEETINGS

a. The Medical Rehabilitation Planning Board will meet as required to serve the needs of the patient(s) referred to the Board.

b. The secretary to the Chief, RMS, will notify those designated to participate in sufficient time to prepare and to ensure their presence at the meeting. Summaries of background information, such as clinical findings, Social Work assessment, study, vocational appraisal, RMS summaries and evaluations, will be brought to the meeting.

4.05 PROCEDURES OF THE BOARD

a. The Board will review the patient's problems and each member of the Board will present an evaluation of the overall problem and possible solutions. The patient will participate in the proceedings.

b. The case manager will inform the Board of the patient's eligibility for vocational rehabilitation services and will work with the VA Regional Office or the State Rehabilitation Agency to provide training and/or services.

c. The Board will develop a rehabilitation plan for each patient and set a definite date for a review of progress, an evaluation of results and the need for further planning.

d. All aspects of the Board's recommendations which can be effected within the medical center will be completed prior to discharge of the patient.

4.06 REPORT OF BOARD ACTION

A copy of the Medical Rehabilitation Planning Board's findings and recommendations, including a complete review of the social, mental and physical condition of the patient, will be placed in the medical record.

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CHAPTER 5. DRIVER TRAINING FOR THE HANDICAPPED VETERAN

CHAPTER 5. DRIVER TRAINING FOR THE HANDICAPPED VETERAN

5.01 STATEMENT OF POLICY

a. Driver training for the handicapped, within VA (Department of Veterans Affairs), is designed to provide eligible veterans and certain military personnel with instruction, practice and evaluation of the special adaptive equipment needed to independently operate a motor vehicle. VA facilities will adhere to the regulations of the State Department of Motor Vehicles.

b. All VA driver training programs will be authorized by VA Central Office with concurrence by Regional and medical center Directors (see par. 5.07).

5.02 ORGANIZATIONAL PLACEMENT

RMS (Rehabilitation Medicine Service) will be responsible for administering the Driver Training Program.

5.03 BUDGET AND FISCAL

a. Existing driver training centers are issued an annual operating fund to be used for the VA Driver Training Program.

(1) Newly established centers must utilize local Medical Care Funds to maintain their programs.

(2) Within the total amount provided, medical centers will be expected to cover all future medical care requirements of the program; this includes money for:

(a) Maintenance and fuel,

(b) Purchase of additional equipment,

(c) Teaching materials,

(d) Replacement vehicles, and

(e) Any other purpose with the exceptions of research and staff education.

NOTE: This will preclude requesting additional funds from VA Central Office.

b. Funds may be withdrawn and redistributed to other driver training centers based on periodic reviews of each program. VA medical centers should establish a central funding point to facilitate the reporting of program costs as directed by VA Central Office.

5.04 REPLACEMENT OF DRIVER TRAINING VEHICLES

a. VA medical centers with designated driver training programs may purchase replacement or additional vehicles by utilizing monies from their annual operating fund. Replacement of currently owned vehicles should be processed through the Facility Replacement Program. Selection of the type and size of replacement vehicle should be determined locally, based on need and previous history of training and disability type.

b. Suitable training vehicles which are received as loans or gifts from service organizations and automobile dealerships may be utilized in a VA Driver Training Program, but only as a supplement to the GSA (General Services Administration) purchased vehicle.

(1) Loaned vehicles must be insured by the individual or company which loans the vehicle to the agency.

(2) The use of a loaned vehicle, at any medical center, will be approved by VA Central Office in accordance with VA regulations.

5.05 AUTOMOBILE AND ADAPTIVE EQUIPMENT REQUIREMENTS

a. The basic automobile utilized in driver training should have certain specifications as listed:

(1) A sedan (current Federal Specification Number).

(2) Compact or mid-size model sedan, two-door.

(3) Customarily furnished equipment as:

(a) Windshield washer and wipers with adjustable speed,

(b) Heater,

(c) Courtesy lighting,

(d) Lamps and switches, and

(e) Clock.

(4) Automatic transmission.

(5) Power locked doors.

(6) Power disc brakes.

(7) Power windows.

(8) Power steering.

(9) Air-conditioning.

(10) A four or six cylinder engine.

(11) A minimum 70 ampere battery.

(12) A minimum 50 ampere alternator.

b. Optional equipment includes:

(1) Front seat with controls for six-way power movement for driver. NOTE: Latches are to be located at the top of the backrest and automatic unlocking seat devices are acceptable.

(2) Right and left remote control outside mirrors.

(3) Horn switch (not to be imbeded in the steering wheel).

(4) Sufficient space between the rear of the front seat and the back seat to allow for the loading, storage and unloading of a wheelchair. NOTE: Seat belt, shoulder harnesses and their hardware should be placed to allow for easy access of a wheelchair.

(5) Tilt adjustable steering wheel.

(6) Dual control foot brakes (installed by the VA medical center staff).

(7) Deicer and defogger on rear windows.

(8) Rear window wiper.

(9) Belts, shoulder (must not be impact type) on chest and lap.

(10) Arm rests.

(11) Vinyl upholstery.

(12) State of California emission controls on all vehicles issued in that State.

NOTE: The automobile should be delivered FOB (free on board) destination to nearest dealer who will prepare the automobile for drive-a-way delivery.

c. Adaptive equipment will be purchased and installed by the RMS or Engineering Service, or by local contract. Purchases costing less than $1,000 (retail) need not be approved by program officials in VA Central Office. Items that should be considered for use in these vehicles include:

(1) Hand control with dimmer switch and horn button (reversible i.e., right and left of steering column).

(2) Ignition key adapter.

(3) Dimmer switch on steering post (for left foot amputees).

(4) Transfer bar inside (portable).

(5) Driver cuffs (inserts in spinner base).

(6) Assorted safety belts.

(7) Panavision rear view mirrors.

(8) Parking brake extension.

(9) Left foot gas pedal.

(10) Right turn signal adapter.

(11) Shift lever extension.

(12) Spinner mount receivers for various assistive devices.

(13) Gutter hook or swing-in handle.

(14) Driver training sign.

(15) Slide boards (with varied designs).

(16) First aid kits and fracture splints.

d. Due to the specialized needs of the patient user and the adaptive equipment technology, it is necessary that the VA driver training instructor be involved in the entire purchase, selection and installation process of this equipment.

5.06 INSURANCE COVERAGE

To ensure that adequate liability insurance coverage is provided, an annual contract has been established by VA Central Office to automatically cover the program in any VA medical center where there is approved driver training. Coverage under this contract is for bodily injury and property damage. Employee and patient insurance coverage is automatically assumed by VA.

5.07 DRIVER TRAINING INSTRUCTORS

The individual assigned as driver training instructor will be a professional rehabilitation therapist with appropriate credentials to teach driver training. The instructor should be certified as a driver instructor in the state in which the medical center is located. In addition, driver training instructors must have received training in the VA approved instructors orientation course, or its equivalent. Exceptions to these requirements must be submitted to VA Central Office (117B) for approval.

5.08 QUARTERLY REPORT

The Driver Training Program Report (original and one copy) should reach VA Central Office (13/117B) not later than 10 work days following the end of the reporting period (quarter). This report (RCS 10-0099) should be submitted on VA Form 10-4790, Driving Training Program Report.

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CHAPTER 6. WORK RESTORATION PROGRAM

CHAPTER 6. WORK RESTORATION PROGRAM

6.01 STATEMENT OF POLICY

a. Through the use of purposeful activity the work restoration program serves as a catalyst to encourage persons with dysfunction to move from a dependent to a productive state in accordance with the demands of society.

b. The work restoration program includes:

(1) Prevocational exploration,

(2) Work evaluation,

(3) Incentive therapy,

(4) Compensated Work Therapy, and

(5) Job placement, and

(6) Follow-up.

c. The Vocational Rehabilitation Case Manager and the Therapeutic Printing Plant Programs are incorporated under this chapter.

6.02 GENERAL PROVISIONS

a. The work restoration program is designed to meet the needs of patients by assessing the patient's strengths, skills and needs leading to appropriate job placement.

b. The health care professionals in RMS (Rehabilitation Medicine Service) assigned to these activities should include:

(1) A case manager,

(2) An occupational therapist,

(3) A vocational rehabilitation specialist,

(4) A manual arts therapist, and

(5) Educational therapists and other staff who contribute to the vocational rehabilitation process and who should be called upon when needed, depending upon their privileges.

c. It is important that the VHA (Veterans Health Administration) vocational rehabilitation team work closely with the Veterans Benefits Administration,

the State Department of Vocational Rehabilitation, and with other resources within the community.

6.03 PROGRAM OBJECTIVES

The Program objectives are to:

a. Assess patient's needs leading to appropriate job/task placement.

b. Increase the individual's independence and productivity.

c. Develop socially acceptable behavioral patterns.

d. Increase attention span and work tolerance.

e. Increase social awareness and group interaction.

f. Increase self-confidence and self-esteem.

g. Encourage good work habits, which will aid the patient in meeting the physical and psychosocial demands in society, emphasizing:

(1) Reliability,

(2) Punctuality,

(3) Productivity,

(4) Personal responsibilities, and

(5) Acceptance of supervision.

h. Instruct patient in work simplification and ergonomics.

6.04 DEFINITIONS

a. Compensated Work Therapy Program. The Compensated Work Therapy Program is a "Work-for-Pay" Program for inpatients and outpatients. The major component is a work regimen with monetary incentives derived from contracts with private industry or other sources outside VA (Department of Veterans Affairs). Reimbursements to participants in the program are related to their productive capabilities. Every effort is to be made to create a realistic work environment. It is essential that earnings be commensurate with wages paid in the community for essentially the same quality and quantity of work and that payments to the patient be prompt and at regular intervals. Although industrial business practices are utilized to simulate usual working conditions, therapy is the objective.

b. Incentive Therapy Program. The Incentive Therapy Program is another "Work-for-Pay Program" provided for under 38 U.S.C. (United States Code) 1718(a) which authorizes an assignment of patients to various hospital work situations. Since the work is considered of economic benefit to the hospital, the veteran must receive remuneration for the accomplished tasks. Under 38 U.S.C. 1718, veterans referred to this program are not held or considered as employees of the United States for any purpose.

c. Vocational Case Management Program. The Vocational Case Management Program is an integrated approach to the provision of vocational rehabilitation services which places special emphasis on bringing the full

resources of VA and the community to bear on the vocational rehabilitation of disabled veterans.

d. Therapeutic Printing Plant Program. The Therapeutic Printing Plant Program provides an environment to teach printing and reproduction techniques to referred veterans with the ultimate goal of preparing these veterans for possible employment in the community. Regulations prepared by the Joint Committee on Printing prohibit the use of this program for anything but "therapy."

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CHAPTER 7. EDUCATION IN REHABILITATION MEDICINE

CHAPTER 7. EDUCATION IN REHABILITATION MEDICINE

7.01 STATEMENT OF POLICY

Education and training are essential to the maintenance of high standards of professional practice. Changing standards of practice, scientific advances, and improved technology necessitate continued professional competency. A program of staff development and continuing education planned and implemented by RMS (Rehabilitation Medicine Service) enhances the quality of care given to veterans and facilitates a program of continuous quality improvement. The content of these programs reflects current health care practice in the delivery of rehabilitation and the results of Quality Assurance activity.

7.02 CONTINUING EDUCATION/STAFF DEVELOPMENT

a. Continuing education is expected of every professional within RMS service. The scope of education will be influenced by:

(1) Needs assessments,

(2) Quality assurance and utilization review results,

(3) Changing practice delivery, and

(4) Other significant factors.

b. Personal continuing education plans should be formulated, reviewed and adjusted to meet changing needs.

c. RMS educational activities may be administered by:

(1) RMEC (Regional Medical Education Center),

(2) REP (Rehabilitation Education Program),

(3) Educational institutions,

(4) In-services,

(5) Teleconferences,

(6) Workshops,

(7) Seminars,

(8) Staff meetings,

(9) Conferences, and

(10) Grand Rounds.

d. The use of local controlled education funds is encouraged to assist staff in attendance at relevant continuing education programs. Tuition support money intended for recruitment and retention of occupational therapists and physical therapists should be sought, annually, through the Associate Chief Medical Director for Academic Affairs.

e. RMS staff should be authorized and encouraged to attend and actively participate in appropriate professional meetings.

f. Each RMS section is responsible for providing, on a regular basis, an in-service education program to staff which addresses scope of practice of that section.

g. RMS will provide an in-service training program for the medical center professional staff targeted to the medical center's mission, clinical rehabilitation service delivery, and the principles of continuous quality improvement.

7.03 TRAINING PROGRAMS

a. Residency programs in RMS established in VA facilities must meet criteria in accordance with VHA (Veterans Health Administration) Manual M-8, part I, chapter 2.

(1) The facility having a RMS Residency Training program must have a RMS bed service with diagnostic capabilities as required by the American Board of Physical Medicine and Rehabilitation.

(2) Physician staffing patterns shall comply with Board requirements. Resident supervision and graduated responsibilities must follow VHA regulations and ACGME (American Council on Graduate Medical Education) guidelines.

(3) A minimum of two physiatrists must be employed at the VA (Department of Veterans Affairs) medical center in RMS before a Residency Training Program can be instituted.

b. Clinical training affiliations with RMS therapies may be provided at selected VA facilities in accordance with Office of Academic Affairs guidelines.

(1) Each section having a program should have at least 3 professional staff members with one designated as training supervisor by the chief of the section, with concurrence by the Chief, RMS.

(2) Prior to the establishment of a clinical training program, the educational institution should make a formal written request to VA medical centers for this affiliation.

(3) Officials at both the educational institution and VA medical center will co-sign a Memorandum of Affiliation establishing the training program at the medical center. The original document will be retained at the medical center with a copy to the affiliated university.

(4) All affiliated training programs in RMS are decentralized with the exception of:

(a) Funded Occupational Therapy programs, and

(b) Programs that are not accredited by a nationally recognized accrediting body, i.e., Educational Therapy and Manual Arts/Horticultural Therapy.

NOTE: A Kinesiotherapy non-affiliated training programs for qualified candidates may be established with the approval of RMS, VA Central Office (117B).

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CHAPTER 8. RESEARCH IN RMS (REHABILITATION MEDICINE SERVICE)

CHAPTER 8. RESEARCH IN RMS (REHABILITATION MEDICINE SERVICE)

8.01 STATEMENT OF POLICY

RMS (Rehabilitation Medicine Service) research is one of the processes used to validate and improve the treatment of veterans patients. RMS will promote a climate receptive to rehabilitation research activities and the applications of research findings in the clinical setting.

8.02 GENERAL PROVISIONS

a. RMS staff will be encouraged to initiate research activities directed toward development of relevant, reliable data in all veteran rehabilitation facilities.

b. RMS research will be conducted under the auspices of the Research and Development Committee at VA (Department of Veterans Affairs) medical centers, subject to pertinent regulations and guidelines.

c. RMS research, including the preparation and publication of professional papers, will be accomplished in accordance with policies and procedures prescribed in M-3, part I.

8.03 SCOPE

The scope of RMS research includes:

a. Clinical research that studies patient needs, care, or aspects of illness.

b. Studies relating to priority aspects of the VA mission or objectives critical to RMS.

c. Studies by RMS affiliated students in conjunction with their clinical experience or by graduate students who have obtained permission to use the VA setting.

d. Cooperative or individual studies that have been funded by VA Central Office or its subdivisions. Sources include:

(1) RAG (Research Advisory Group) program,

(2) Merit Review Program, and

(3) Rehabilitation Research and Development Program.

CONTENTS

CHAPTER 9. SCOPE OF PRACTICE

CHAPTER 9. SCOPE OF PRACTICE

9.01 STATEMENT OF POLICY

a. A scope of practice invests a specified rehabilitation medicine therapist with the authority and responsibility of providing treatment to referred VA (Department of Veterans Affairs) patients.

b. A scope of practice will be granted by individual VA health care facilities based upon the individual therapist's:

(1) Formal education,

(2) Licensure and certification status,

(3) Experience,

(4) Competencies,

(5) Abilities, and

(6) Other relevant information, such as clinical specialty areas.

c. The scopes of practice for the therapy disciplines of Kinesiotherapy, Occupational Therapy and Physical Therapy cannot exceed the "Standards of Practice" as defined by the respective professional organizations (i.e., American Kinesiotherapy Association, American Occupational Therapy Association and American Physical Therapy Association).

d. A scope of practice for Educational Therapy is found in paragraph 9.03.

e. A scope of practice for Manual Arts Therapy is found in paragraph 9.04.

NOTE: "Clinical Privileges" for the therapy disciplines will be used in accordance with established VA regulations.

9.02 GENERAL PROVISIONS

a. These guidelines are applicable for processing applications for a scope of practice for all rehabilitation therapists irrespective of geographic location or organizational assignment. The process for granting renewal of a scope of practice will be the same as that for granting the initial scope of practice.

b. The supervisor of the respective rehabilitation therapy section (educational therapy, kinesiotherapy, manual arts therapy, occupational therapy, physical therapy) will develop written criteria and procedures, which must be approved by the Chief, RMS or physician designee, for granting a scope of practice to an individual rehabilitation therapist.

(1) These criteria and procedures include:

(a) Recommended levels of continuing education,

(b) Quality assurance, and

(c) Utilization guidelines, such as standards established by the respective national therapy association.

(2) The criteria and procedures will specify the appropriate level of performance required to receive, maintain or renew this status at each of the defined levels of scope of practice for rehabilitation specialists.

c. Section supervisors will be responsible for submitting the initial application for a scope of practice and shall apply for renewal biennially for self and staff.

d. Each RMS will have procedures for reviewing initial and renewal requests for a scope of practice.

e. Final approval will be indicated by the signature of the chief of the respective section, and of the Chief, RMS.

f. Staff applications for renewal will include:

(1) Evidence of continued competency appropriate to the areas of practice, and

(2) Supervisory certification indicating all performance requirements have been met satisfactorily.

g. With the approval of the Chief, RMS, or designee, therapists who have already demonstrated competency in a specific skill, and were already conducting treatment programs prior to issuance of the scopes of practice mandate, may continue to practice this skill.

9.03 EDUCATIONAL THERAPY

The "Scope of Practice" is the level of practice granted to the experienced educational therapist.

a. The majority of the educational therapist's patient education activities involves work of a highly complex nature and is performed independently utilizing the supervisory educational therapist or designee as a consultant.

b. To qualify for practice that exceeds entry-level skills, the applicant must have demonstrated competency in a health care setting for a least 1 year during the previous 3 years and provide documentation of continuing education in the applicant's current area of practice. The general scope of practice for educational therapists includes, but is not limited to, the following:

(1) Assessment by the:

(a) Analysis of formal educational preparation prior to acceptance in the program,

(b) Analysis of educational needs to prepare for GED (General Educational Development) testing, and

(c) Analysis of special educational needs in order to prepare for vocational changes or upgrading, or for other areas of need; and

(2) Treatment by:

(a) Conducting adult basic education for semi-literate individuals.

(b) Providing remedial instruction for individuals with educational handicaps, learning disabilities, and/or cognitive dysfunction.

(c) Implementing academic and developmental education techniques.

(d) Counseling in marketable job skills.

(e) Providing expertise in poetry, prose, drama, and other educationally creative areas.

(f) Arranging GED testing.

(g) Providing work-based avocational activities.

(h) Assisting with patient newspapers, and

(i) Teaching:

1. Typing,

2. Word processing,

3. Computer technology, and

4. Current events.

9.04 MANUAL ARTS THERAPY

A "Scope of Practice" is the level of practice granted to the experienced manual arts therapist (sometimes referred to as vocational rehabilitation therapist).

a. The majority of the manual arts therapist's patient care activities involves work of a highly complex nature and are performed independently utilizing the supervisory manual arts therapist as a consultant.

b. To qualify for practice that exceeds entry-level skills, the applicant must have demonstrated competency in a health care setting for at least 1 year during the previous 3 years and provide documentation of continuing education in the applicant's current area of practice. The general scope of practice for manual arts therapists includes, but is not limited to, the following:

(1) Assessment of the:

(a) Functional level and work potential utilizing:

1. Job sample evaluations,

2. Work adjustment evaluations, and

3. Standardized vocational testing instruments; and

(b) Ability levels.

(2) Treatment by:

(a) Promoting optimal functioning in work settings by modifying the environment;

(b) Providing structured work situations through the work-for-pay assignments;

(c) Promoting sociability and interdependence by providing group work situations;

(d) Providing Compensated Work Therapy (work-for-pay) as a therapeutic assessment;

(e) Conducting Incentive Therapy (work-for-pay) to evaluate work tolerance and low-level work performance;

(f) Providing work-based avocational activities to reduce hospitalization; and

(g) Providing pre-discharge patient education and coordination of community resources to increase successful community re-entry.